STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #65928.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility identified a census of 32 residents. The sample included 17 residents. Based on observation and interview the facility failed to provide a comfortable home like environment in 2 of 2 common bathing rooms. Findings included: - During environmental tour on 7/30/13 at 3:27 P.M. observation revealed the floor in the whirlpool room was worn and discolored in areas and had an area in front of the whirlpool that was marred. During interview on 7/30/13 at 3:27 P.M. maintenance staff K acknowledged the facility needed to replace the floor. Observation of the shower room on 7/30/13 at 3:30 P.M. revealed a window air conditioner unit with silver adhesive border around a piece of wood. During interview on 7/30/13 at 3:30 P.M. maintenance staff K acknowledged the area around the window unit was unattractive, however, the facility recently placed the air	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 1 conditioning window unit due to the heat in the shower room. The facility failed to provide a comfortable home like environment.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility had a census of 32 residents. The sample included 17 residents. Based upon observation, record review and interviews the facility failed to develop an individualized and comprehensive care plan for 2 (#27, #7) of the 27 residents for nail care, dental, and medications. Findings included:	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 - Review of resident #27's quarterly Minimum Data Set (MDS) 3.0 dated 7/24/13 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, did not have behaviors, was independent with bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, dressing, eating, toilet use, and personal hygiene. An oral assessment dated 1/23/12 included the resident had his/her natural teeth. A dental assessment dated 6/26/13 included the resident had his/her natural teeth. A dental assessment dated 7/25/13 included the resident had his/her natural teeth. The resident's care plan with a print date of 6/21/13 documented the resident had always been neat and tidy, but preferred to be comfortable in his/her home setting. The care plan included an entry that was discontinued (no date as to when the facility discontinued the intervention) that included the resident liked his/her nails long and polished but required staff assistance to keep them well manicured. The care plan included the resident's upper and bottom teeth had some decay, and the licensed nurse performed an oral cavity assessment each month. The care plan included even though the resident did not wear dentures, staff needed to brush the resident's tongue and gums on a daily basis, and staff encouraged the resident to brush three times a day after meals. Review of the resident's clinical record lacked evidence a licensed nurse performed an oral assessment each month as planned.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 Review of the resident's nurse's notes from 6/21/13 to 7/27/13 timed 12:10 A.M. lacked evidence the resident refused to have his/her nails manicured at the nail clinic. On 7/24/13 at 11:14 A.M. observation revealed the resident's fingernails untrimmed and unclean. On 7/29/13 at 11:20 A.M. observation revealed the resident's fingernails were long (untrimmed) and a brown colored substance underneath his/her nails. During interview with the resident on 7/29/13 at 3:48 P.M. the resident stated he/she had his/her natural teeth. On 7/29/13 at approximately 3:55 P.M. licensed nurse H stated the licensed nurses performed dental assessments on a monthly basis and the assessments were in the resident's clinical record. On 7/29/13 at 4:00 P.M. licensed nurse C stated since the resident was not a diabetic, direct care staff could manicure the resident's fingernails. Licensed nurse C stated the facility held a nail clinic every other week. Licensed nurse C stated he/she discontinued the nail care from the resident's care plan because it was not gender appropriate. Licensed nurse C confirmed the resident's care plan did not address the resident's nail care. On 7/29/13 at 4:10 P.M. licensed nurse C stated the resident had his/her natural teeth, and did not wear dentures and the resident's care plan was inaccurate regarding the dentures. On 7/30/13 at approximately 7:45 A.M. the	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 resident stated staff trimmed and cleaned his/her nails approximately every 2 weeks. On 7/30/13 licensed nurse H at 11:50 A.M. stated staff performed the resident's nail care because the resident would not do his/her nail care. Licensed nurse H stated the facility held a nail clinic 2 weeks out of each month (on a Sunday) and staff should trim and clean the resident's nails during the nail clinic. Licensed nurse H stated the nail clinic documentation should include whether the resident refused nail care. On 7/30/13 at 12:45 P.M. licensed nurse B stated he/she reviewed the nail clinic documentation but the facility did not keep the documentation. Licensed nurse B stated the licensed nurse should document in the nurse's notes whether the resident refused nail care during nail clinic times. Licensed nurse B stated the resident self-isolated himself/herself in his/her room, and sometimes did refuse to attend the nail clinic, but the resident would allow staff to perform nail care in his/her room on nail clinic days. The facility failed to develop a comprehensive and individualized care plan regarding the resident's nail care and dental needs. - Review of resident #7's quarterly Minimum Data Set (MDS) 3.0 dated 5/15/13 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, had delusions, had verbal behavioral symptoms directed toward others 1 to 3 days during the 7 day assessment period, and rejected care 4 to 6 days during the 7 day assessment period. The MDS coded the resident was independent with bed mobility, transfers, walking in the room/corridor,	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5	F 279		

locomotion on/off the unit, dressing, eating, toilet use, personal hygiene, and was occasionally incontinent of urine. The MDS coded the resident received an antipsychotic, an antianxiety and an antidepressant 7 days during the 7 day observation period.

The resident's Psychotropic Use Care Area Assessment (CAA) dated 11/26/12 included the resident received antipsychotic and antidepressant medications, and the facility would develop a care plan that addressed the resident's psychotropic use due to the potential for adverse side effects related to the medications.

A pharmacist's consultation note addressed to the resident's physician dated 4/30/13 included the resident received Trazodone (an antidepressant) 150 milligrams (mg) each night for depression. The note included the pharmacist asked the resident's physician to evaluate if the Trazodone could be reduced to 100 mg each night. On 6/30/13 the physician declined to reduce the Trazodone and documented the resident had trouble sleeping at night, and to continue the Trazodone at the current dose of 150 mgs.

A note to the resident's attending Physician/Prescriber from the consultant pharmacist dated 6/28/13 included the resident received Vistaril (used to treat anxiety) 50 mg each night for insomnia related to sadness. The consultant pharmacist asked the resident's physician's to evaluate to see if a dose reduction of the Vistaril would be appropriate at that time. On 6/30/13 the physician responded and documented the resident described irritability at night and the Vistaril addressed that and to continue with the current dose of the Vistaril.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 6 The resident's care plan dated 11/24/12 to present with a print date of 7/2/13 did not address the resident's insomnia (trouble sleeping) and/or irritability. The resident's care plan included the resident was incontinent of urine, the resident wore an incontinent brief, and the resident required staff to remind him/her to go to the bathroom on arising, before meals and before bedtime. Observation on 7/30/13 at 9:30 A.M. the resident ambulated to the activity room and was dressed appropriately. On 7/30/13 at approximately 8:00 A.M. direct care staff D stated the resident got up each day around 5:30 A.M. to 6:00 A.M., dressed himself/herself and went outside to smoke. Direct care staff D stated the resident went back to bed after smoking and got up again around 9:00 A.M. to 9:30 A.M. Direct care staff D stated the resident did not require staff assistance with activities of daily living (ADLs) task including toileting. On 7/30/13 at 11:15 A.M. the resident stated he/she independently performed his/her ADLs including toileting. On 7/30/13 at 11:56 A.M. licensed nurse H stated the resident was not on a toileting program. On 7/30/13 at 12:02 P.M. licensed nurse C stated the resident had stress incontinence, the staff asked the resident if he/she had gone to the bathroom to trigger him/her to toilet self, but the resident was not on a toileting program as described on the care plan.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7 On 7/30/13 at approximately 12:15 P.M. nurse consultant AA confirmed the resident's care plan did not address the resident's insomnia or irritability. The facility failed to develop a comprehensive and individualized care plan that addressed the resident's insomnia and irritability and toileting needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility identified a census of 32 residents. Sample size included 17 residents. Based on observation, record review, and interviews, the facility failed to revise the care plan for 1 (#3) resident of the sample for hospice and activities	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8 of daily living. Findings included: - Resident #3's physicians order sheet (POS) dated 6-29-13 revealed diagnoses of neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and pseudoparkinsonism (Parkinson's disease like symptoms- resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness). The quarterly (MDS) Minimum Data Set 3.0 dated 7-10-2013 listed a BIMS (Brief Interview for Mental Status) summary score of 12 which indicated cognition was moderately impaired. The MDS documented the resident required extensive assistance of one person assist with bed mobility and transfers. The MDS documented the resident with a urinary toileting program and was always incontinent of urine. The care plan for increased risk for falls dated 7-6-2013 documented to use the sit to stand lift with 2:1 (two staff or one staff and device to one resident) when assisting. The care plan documented the resident could turn herself/himself but needed staff cueing to change positions. The care plan documented staff to encourage and remind the resident to use the urinal while in bed and staff to make sure the urinal was within reach. Two staff were needed to take the resident to the bathroom every two hours when he/she was up and check him/her hourly at night but check and change every two hours at night. The care plan lacked interventions for hospice care.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 Observation on 7-30-13 at 7:45 A.M. revealed two staff assisted the resident from the wheel chair to the bed using the sit to stand lift. It was noted the resident required two staff for bed mobility. Observation on 7-30-13 at 9:45 A.M. revealed two staff repositioned the resident in bed. The resident was dependent on staff for bed mobility. Staff did not offer the resident the urinal and it was not within reach for the resident. Direct care staff F, interviewed on 7/30/13 at 03:43 P.M. revealed he/she did not use a urinal. Staff offered him/her the urinal if he/she did not want to go into the bathroom, but he/she never used it. He/she really did not reposition himself/herself. The resident was not capable of repositioning and staff did more work than the resident did. Direct care staff D, interviewed on 7-30-13 at 05:12 P.M. revealed the resident started declining a few months ago. It was a slow decline and started about April or May. The last few weeks he/she declined fast which started the beginning of July. The past few weeks staff was using two staff assist when doing cares. Nursing staff H, interviewed on 7-30-13 at 05:19 P.M. revealed the early signs of decline for this resident started in January. Starting in May, he/she had gotten worse. At the beginning of June staff started using two staff assist when doing cares. Administrator staff C, interviewed on 7-30-13 at 04:20 P.M. revealed staff did more for the resident now. Staff repositioned the resident every two hours and checked and changed this resident in order for the resident to be clean and	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 10 dry. He/she agreed the care plan needed updated. Administrator staff A, interviewed on 7-30-13 at 02:30 P.M. revealed the resident began Hospice services on 7/17/13. The undated facility provided policy and procedure for comprehensive care plan documented a comprehensive care plan must be reviewed and revised as needed by the interdisciplinary team at least quarterly and with any changes in resident status. Each resident's care plan was individualized and would reflect the physical and psychosocial issues/concerns and interventions for the resident. The Director of Nursing and the interdisciplinary team would monitor care plans on an ongoing basis to ensure they reflected the current status of the resident. The interdisciplinary team met weekly. The team would review the problems, goals and interventions and would revise the care plan as needed. The facility failed to revise this resident's care plan to include hospice and changes in activities of daily living.	F 280		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This Requirement is not met as evidenced by: The facility identified a census of 32 residents. The sample was 17 residents of which 3 were reviewed for activities of daily living (ADLs). Based on observation, record review, and	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 11	F 311		

interview, the facility failed to ensure two (#26, #27) residents received nail care to maintain his/her well being.

Findings included:

- The July 2013 Physician's Order Sheet (POS) for resident #26 documented diagnoses of paranoid type schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception and emotional reaction) and diabetes mellitus (DM, when the body can not use glucose, there was not enough insulin made or the body could not respond to the insulin).

The Annual Minimum Data Set (MDS) 3.0 dated 5/29/13 revealed a Brief Interview for Mental Status (BIMS) score of 15 (13 to 15 indicated cognitively intact) and the resident required cueing for ADLs.

The Care Area Assessment (CAA) dated 5/29/13 for cognition documented this resident was at risk for cognitive loss due to fluctuations in glucose and oxygen levels due to medical conditions. He/she had schizophrenia, occasional agitation and psychosis (any major mental disorder characterized by a gross impairment in reality testing). These diagnoses could have a negative impact on cognition. The CAA for ADLs did not trigger.

The care plan for this resident updated 6/10/13 revealed the resident needed help to keep his/her fingernails short, as he/she had trouble trimming them independently.

Review of nurse's notes for July 2013 failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 12 document a refusal of nail care for this resident. Observation on 07/24/13 at 12:30 P.M. revealed this resident's fingernails were long with a visible dark brown substance under them. Observation on 7/25/13 at 3:30 P.M. revealed this resident's fingernails were long with a visible dark brown substance under them. Observation on 7/30/13 at 7:30 A.M. revealed this resident's fingernails were long with a visible dark brown substance under them. Interview on 7/30/13 at 11:20 A.M. direct care staff D stated this resident only needed cueing for ADLs. He/she offered assistance to the resident, and this resident wanted to trim his/her own fingernails, but needed supervision. Interview on 7/30/13 at 2:45 P.M. licensed nursing staff H stated the resident needed help trimming his/her own fingernails, and the nurse had to trim them due to his/her diagnosis of DM. Interview on 7/30/13 at 1:30 P.M. licensed nursing supervisor B stated the nurses should document when a resident refused to have his/her nails trimmed at the nail clinic. The last nail clinic was on 7/27/13. The facility failed to provide a policy on ADLs. The facility failed to provide nail care for this resident. - Review of resident #27's quarterly Minimum Data Set (MDS) 3.0 dated 7/24/13 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, did not have	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 13 behaviors, was independent with bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, dressing, eating, toilet use, and personal hygiene. The resident's care plan with a print date of 6/21/13 documented the resident had always been neat and tidy, but preferred to be comfortable in his/her home setting. The care plan included an entry that was discontinued (no date as to when the facility discontinued the intervention) that included the resident liked his/her nails long and polished but required staff assistance to keep them well manicured. Review of the resident's nurses notes from 6/21/13 to 7/27/13 timed 12:10 A.M. lacked evidence the resident refused to have his/her nails manicured at the nail clinic. On 7/24/13 at 11:14 A.M. observation revealed the resident's fingernails were untrimmed and unclean. On 7/29/13 at 11:20 A.M. observation revealed the resident's fingernails were long (untrimmed) and a brown colored substance underneath his/her nails. On 7/29/13 at 4:00 P.M. licensed nurse C stated the resident was not a diabetic, therefore, direct care staff could manicure the resident's fingernails. Licensed nurse C stated the facility held a nail clinic every other week. Licensed nurse C stated he/she discontinued the nail care from the resident's care plan because it was not gender appropriate. Licensed nurse C confirmed the resident's care plan did not address the resident's nail care.	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 14 On 7/30/13 at approximately 7:45 A.M. the resident stated staff trimmed and cleaned his/her nails approximately every 2 weeks. On 7/30/13 at 11:50 A.M. licensed nurse H stated staff performed the resident's nail care because the resident would not do his/her nail care. Licensed nurse H stated the facility held a nail clinic 2 weeks out of each month (on a Sunday) and staff should trim and clean the resident's nails during the nail clinic. Licensed nurse H stated the nail clinic documentation should include whether the resident refused nail care. On 7/30/13 at 12:45 P.M. licensed nurse B stated he/she reviewed the nail clinic documentation but the facility did not keep the documentation. Licensed nurse B stated the licensed nurse should document in the resident's nurse's notes whether the resident refused nail care during nail clinic times. Licensed nurse B stated the resident self-isolated himself/herself in his/her room, and sometimes refused to attend the nail clinic, but the resident would allow staff to perform nail care in his/her room on nail clinic days. The facility failed to ensure this resident's nails were trimmed and clean.	F 311		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 15 function as possible. This Requirement is not met as evidenced by: The facility identified a census of 32 residents. The sample was 17 residents. Based on observation, record review and staff interview, the facility failed to assess and provide interventions for one of one residents reviewed for urinary incontinence. (#3) Findings included: - Resident #3's (POS) Physician's Order Sheet dated 6-29-13 revealed diagnosis of neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system). The 7-10-2013 Quarterly Minimum Data Set 3.0 (MDS) documented a Brief Interview for Mental Status (BIMS) summary score of 12 which indicated moderate cognitive impairment. The MDS documented the resident had a urinary toileting program and was always incontinent of urine, and required extensive assistance of one person for toileting. The Care Area Assessment (CAA) for urinary incontinence and indwelling catheter dated 10-31-2012 documented he/she had multiple episodes of incontinence on his/her bladder diary. The care plan dated 7-6-2013 documented staff encouraged and reminded the resident to use the urinal while in bed. Staff made sure the urinal was within reach, staff toileted him/her prior to placing in bed, encouraged him/her to allow staff to use protective creams as ordered, obtain a 3-day voiding diary yearly and based on his/her diary and the nurse's assessment, the resident	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 16	F 315		

needed two staff to assist him/her to the bathroom every two hours when he/she was up and checked him/her hourly at night but check and change every two hours at night. Staff provided pericare every two hours and after incontinent episode. The resident took a diuretic and had to go to the bathroom often and quickly after he/she received it. The resident wore an incontinent brief to help him/her maintain his/her dignity and to protect his/her clothing. The resident required staff to change the brief and help him/her make sure he/she was clean and dry, he/she did not wish to wear a brief when he/she was in bed.

Review of the clinical record on 7-30-13 lacked a bladder assessment and bladder diary.

Observation on 7-25-13 at 03:11 P.M. revealed the resident was incontinent of urine on the bed pad. Staff completed peri care and applied skin protectant cream to the groin area. Direct care staff G stated staff did not put a brief on the resident when he/she was in bed so he/she could air out because the resident had some red spots. Staff did not place the urinal within reach of the resident.

Observation on 7-30-13 at 7:45 A.M. with direct care staff D and E revealed the resident's brief was dry. The resident refused to use the toilet. Staff completed pericare and the residents groin was red in color. Nursing staff B entered the resident's room and instructed the direct care staff to wash the groin with soap and water. The resident refused skin protectant barrier cream. Staff did not place the urinal within reach of the resident.

Observation on 7-30-13 at 9:42 A.M. Nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 17	F 315		

B spoke with the resident and stated he/she spoke to the hospice nurse and they were going to bring powder to use instead of the protective cream.

Observation on 7-30-13 at 9:45 A.M. with direct care staff D and F revealed the resident was incontinent of urine. Staff changed the resident's bedding due to being wet with urine. The resident's gown was wet with urine and was changed by staff. The resident's groin was red in color and the resident refused peri care and skin protectant cream stating "No". Staff did not offer the resident the urinal or place it within reach.

Direct care staff G, interviewed on 7-25-13 at 03:11 P.M. revealed staff did not put a brief on the resident when he/she was in bed so he/she could air out because he/she had some red areas.

Direct care staff F, interviewed on 7-30-13 at 3:43 P.M. revealed the resident was on an every 2 hour toileting program. Every 2 hours when staff repositioned him/her, we would check to see if he/she needed to go to the bathroom and staff kept track if he/she was incontinent. He/she did not use a urinal. We offer him/her the urinal if he/she does not want to go into the bathroom, but he/she never used it. If he/she refused to get up and was wet staff rolled him/her over and put new bed pads under him/her and did peri care.

Direct care staff D, interviewed on 7-30-13 at 5:12 P.M. revealed the resident refused the urinal and refused to sit on the toilet.

Administrative nursing staff C, interviewed on 7-30-13 at 04:20 P.M. revealed staff repositioned the resident every two hours and checked and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 18 changed this resident in order for the resident to be clean and dry. He/she had peri area issues and staff used a protective cream and nystatin. If a resident was incontinent on a 3 day voiding trial the staff would place the resident on a toileting program. Nursing staff did a voiding diary yearly at the time of the comprehensive assessment. He/she agreed the resident was on a toileting program. He/she stated he/she had attempted 3 times to do a voiding diary on the resident but the charting was inaccurate. He/she failed to reveal documentation when the last voiding diary was completed. The facility failed to provide a policy and procedure on urinary incontinence. The facility failed to assess this cognitively impaired resident and provide effective interventions for the presence of incontinence.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 32 residents. The sample included 17 residents. Based on observation and interview the facility failed to provide a safe bathing environment in 1 of 2 bathing rooms. Findings included:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 - During environmental tour on 7/30/13 at 3:27 P.M. observation revealed the whirlpool room lacked a non-skid surface on the laminate type floor in front of the whirlpool and shower and on the tile floor inside the shower. Observation also revealed exposed bolt heads on the floor. During interview on 7/30/13 at 3:27 P.M. maintenance staff K acknowledged the slick floors in the whirlpool room and lack of non-skid surfaces to prevent falls in the shower. He/she also stated the area in front of the whirlpool was where the lift used to be bolted to the floor. The facility failed to provide a safe bathing environment for the residents.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 20 drugs. This Requirement is not met as evidenced by: The facility had a census of 32 residents. The sample included 17 residents. Based upon observation, record review and interviews the facility failed to ensure 2 (#13, #7) of the 10 sample residents were free of unnecessary medications. Findings included: - Review of resident's #13's annual Minimum Data Set (MDS) 3.0 dated: 6/5/13 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, had hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind), delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue), and rejected care on a daily basis during the 7 day observation period. The MDS coded the resident received an antipsychotic, an antianxiety, and an antidepressant 7 days during the seven day observation period. The resident's Psychotropic Medication Use Care Area Assessment (CAA) dated 6/17/13 included the resident received an antipsychotic, an antianxiety, and an antidepressant medication. The resident's care plan with a print date of 6/26/13 included the resident received Depakote (a mood stabilizer) and Lamictal (used to treat mood disorders).	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 21 Review of the resident's June 2013 Medication Administration Record (MAR) revealed the resident received 250 milligrams (mgs) of Depakote from 9/21/12 until 6/27/13 for a mood disorder. The resident's July 2013 MAR reviewed on 7/29/13 at approximately 10:00 A.M. revealed the resident had received 100 mgs of Lamictal for irritability since 6/24/12. The resident's Monthly Medication Regimen Review dated 10/29/12 and 1/31/13 revealed pharmacist consultant M noted the resident's Lamictal and Depakote and to please consider adding those medications to resident's psychoactive monitoring form. Review of the resident's clinical record lacked evidence to support the facility monitored the effectiveness of the Depakote (until it was discontinued on 6/27/13). The clinical record also lacked evidence to support the facility monitored the effectiveness of the Lamictal. On 7/29/13 at 8:30 A.M. observation revealed the resident ambulated in the hallway. On 7/30/13 at 9:20 A.M. direct care staff E stated he/she completed the behavior monitoring for the facility. Direct care staff stated the facility did not include the resident's Depakote on the behavior monitoring form prior to the resident's physician's discontinuing the medication on 6/27/13. Direct care staff E stated the Lamictal was not included on the resident's behavior monitoring sheets. On 7/30/13 at 9:50 A.M. licensed nurse B stated the facility did not monitor the resident for the	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 22	F 329		

effectiveness of the Lamictal and did not monitor the resident for the effectiveness of the Depakote prior to the medication being discontinued on 6/27/13.

The facility failed to monitor for the effectiveness of the Depakote and Lamictal.

- Review of resident's #7's quarterly MDS dated 5/15/13 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, had hallucinations, delusions, and verbal behavioral symptoms directed toward others 1 to 3 days of the seven day observation period, and rejected care 4 to 6 days of the seven day observation period. The MDS coded the resident received an antipsychotic medication, an antianxiety and an antidepressant 7 days during the 7 day observation period.

The resident's Psychotropic Use Care Area Assessment (CAA) dated 11/26/12 included the resident received an antipsychotic and an antidepressant medication.

The resident's care plan with an effective date of 11/24/12 to present with a print date of 7/2/13 did not address the resident's irritability or insomnia (trouble sleeping).

An initial psychiatric evaluation dated 11/24/12 included the physician would include for the resident to receive 50 milligrams (mg) of Vistaril (used to treat anxiety) at night for insomnia and also per the resident's request. The note included the resident would receive the Vistaril off label (used in a manner not specified in the Federal Drug Administration approved packaging label, or insert) but had been effective.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 23 Review of the resident's July 2013 Medication Administration Record (MAR) revealed the resident had received 50 mgs of Vistaril for insomnia since 12/24/12. Review of the resident's clinical record lacked evidence to support the facility monitored the resident for the effectiveness of the Vistaril. On 7/30/13 at 7:30 A.M., 8:00 A.M. and 8:30 A.M. the resident laid in bed. On 7/30/13 at 9:30 A.M. the resident ambulated to the activity room. On 7/30/13 at 12:15 P.M. consultant nurse AA confirmed the facility did not monitor and/or assess the resident for the effectiveness of the Vistaril. The facility failed to monitor the effectiveness of the Vistaril.	F 329		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 354	Continued From page 24 This Requirement is not met as evidenced by: The facility identified a census of 32 residents. Based on observation, record review, and interview, the facility failed to designate a registered nurse to serve as the director of nursing on a full time basis. Findings included: The facility staffing scheduled for 7/13 lacked documentation of a director of nursing. Multiple observations on 4 of 4 onsite survey days 7/24/13, 7/25/13, 7/29/13, and 7/30/13 failed to note a specific registered nurse who served as the director of nursing. Interview on 7/24/13 at 9:30 A.M. administrative staff A stated there was not a specific registered nurse who served as the director of nursing. The facility failed to employ the services of a director of nursing.	F 354		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by:	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 25 The facility had a census of 32 residents. The sample included 17 residents. Based upon observation, record review and interviews the facility failed to follow up on the consultant pharmacist's irregularity report in a timely manner for 1 (#13) of 10 residents sampled for unnecessary medications. Findings included: - Review of resident's #13's annual Minimum Data Set (MDS) 3.0 dated: 6/5/13 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, had hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind), delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue), and rejected care on a daily basis during the seven day observation period. The MDS coded the resident received an antipsychotic, an antianxiety, and an antidepressant 7 days during the seven day observation period. The resident's Psychotropic Medication Use Care Area Assessment (CAA) dated 6/17/13 included the resident received an antipsychotic, an antianxiety, and an antidepressant medication. The resident's care plan with a print date of 6/26/13 included the resident received Depakote (a mood stabilizer) and Lamictal (used to treat mood disorders). Review of the resident's June 2013 Medication Administration Record (MAR) revealed the resident received 250 milligrams (mgs) of Depakote from 9/21/12 until 6/27/13 for a mood disorder.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 26 The resident's July 2013 MAR reviewed on 7/29/13 at approximately 10:00 A.M., revealed the resident received 100 mgs of Lamictal (used to treat mood disorders) for irritability since 6/24/12. The resident's Monthly Medication Regimen Review dated 10/29/12 and 1/31/13 revealed pharmacist consultant M noted the resident's Lamictal and Depakote and to please consider adding those medications to resident's psychoactive monitoring form. Review of the resident's clinical record lacked evidence the facility had included the above medications on the resident's behavior forms as noted on the pharmacist irregularity report to the facility. This review also revealed the Depakote was discontinued on 6/27/13 but the resident continued to receive the 100 mg of Lamictal. On 7/29/13 at 8:30 A.M. observation revealed the resident ambulated in the hallway. On 7/30/13 at 9:20 A.M. direct care staff E stated he/she did the behavior monitoring for the facility. Direct care staff stated the facility did not include the resident's Depakote on the behavior monitoring form prior to the resident's physician's discontinuing the medication on 6/27/13. Direct care staff stated the Lamictal was not included on the resident's behavior monitoring sheets. On 7/30/13 at 9:50 A.M. licensed nurse B confirmed the facility did not include the Depakote or the Lamictal per the consultant pharmacist's recommendation. The facility failed to follow-up on the pharmacist's nursing irregularity report in a timely manner to	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 27 monitor for the effectiveness of the Depakote and Lamictal.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by:	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 28	F 431		

The facility identified a census of 32 residents. Based on observations of one of two medication rooms, record review and staff interview on one of four days of survey, the facility failed to dispose of expired medications and properly store medications.

Findings included:

- Observations on the locked unit during initial tour on 7-24-13 at 9:15 A.M. with licensed nursing staff H, revealed the medication room refrigerator contained Influenza virus vaccine 5 milliliter (ml) vial unopened with an expiration date of 6/2013. Levemir insulin unopened and frozen and six unopened vials of Novolin R insulin frozen. Medication for a unsampled resident revealed Lorazepam 1 milligrams (mg) tablet with a discard date of 6/13/2013 found in the locked medication cabinet on the wall. The medication room refrigerator revealed a temperature of 14 degrees Fahrenheit at 9:18 A.M.

Licensed staff H, interviewed at 7-24-2013 at 9:31 A.M. revealed he/she agreed that 6 bottles of insulin were frozen in the refrigerator in the medication room. He/she stated frozen insulin was not acceptable. Nursing staff could not use those after they were frozen. He/she agreed the unopened Influenza virus vaccine was expired on 6/2013. He/she agreed the Lorazepam discard date was 6-13-2013.

The facility's policy and procedure for medication storage, storage of medications and biologicals dated 3/2011, revealed medications requiring refrigeration or maintained at a temperature between 36 degrees Fahrenheit and 46 degrees Fahrenheit were kept in a refrigerator with a thermometer to allow temperature monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 29 Outdated, contaminated, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures were removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order existed. The facility failed to dispose of expired medications and properly store medications at appropriate temperatures.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 30 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility identified a census of 32 residents. The sample included 17 residents. Based on observation and interview the facility failed to store and process linen in a sanitary manner. Findings included: - Tour of the laundry room on 7/30/13 at 3:09 P.M. revealed metal containers which contained soiled laundry that were uncovered. Maintenance staff K pulled a curtain that hung around the laundry shoot over and around some of the metal containers, but a container holding soiled linens remained exposed and not covered. During interview on 7/30/13 at 3:09 P.M. maintenance staff K reported staff should pull the curtain which hung around the laundry shoot over the metal containers that contained the soiled clothing and linens. On 7/30/13 at 6:30 P.M. administrative staff A reported the facility had metal lids that staff should use to cover the soiled laundry containers. The facility failed to store and process linen using infection control techniques.	F 441		